VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ GROWTH STIMULATING AGENTS ~

Prior Authorization Request Form

Effective February, 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of Growth Stimulating Agents medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Growth Stimulating Agents medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing Physician:

Name:_____

Phone #:_____

Fax #:_____

Specialty: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Patient Diagnosis: _____

Contact Person at Office: _____

Address: _____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

☐ **Norditropin** Dose & Frequency:_____

☐ **Nutropin** Dose & Frequency: _____

☐ **Omnitrope** Dose & Frequency:_____

For any other growth hormone product, please explain medical necessity for 'non-preferred' product:

Drug: _____

Medical justification: _____

_____

_____

Growth Hormone Stimulation Test # 1	**Test:**	**result:**
Growth Hormone Stimulation Test # 2	**Test:**	**result:**
Patient's Height:		
Patient's Bone Age:		
Patient's Chronological Age:		
Growth Velocity:		
IGF-1 results:		

Other information/ Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

Last Updated 01/08